



New Client & Patient Form

Client Information

Name: _____	Phone: _____
Name: _____	Phone: _____
Address: _____	Email: _____
_____	Email: _____

Please be advised that we do not have a veterinarian on site 24 hours a day

Please initial that you have read the information below

- Do you have a regular veterinarian you would like us to send records to after your visit? YES NO
- If Yes, please provide Name and Phone Number: _____
- Pet Insurance Company: _____ Policy# _____
- If you do not have Pet Insurance, would you like the information? YES NO

Patient Information

Name: _____	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Spayed/Neutered: <input type="checkbox"/>
Breed: _____	Birth: _____ Weight: _____
	Age: _____ Microchip: _____

Staff Instructions: For additional patients, write information below, or reprint this document for each patient.

Patient Name: _____	Species: _____	Breed: _____	Color: _____
Sex: _____	Birthdate: _____	Age: _____	Weight: _____

How Did You Hear About Us?

Referred By: Internet / Website Google/Yahoo Yelp.com Veterinarians.com VCA Website

New Mover / Offer (Email) Social Media (Facebook etc.) VIP Program Hospital Sign Event

Friend / Family / Colleague (Client): _____ Veterinarian _____

Humane Society / Rescue: _____ Breeder / Pet Store: _____ Other: _____

Please sign the following authorization for treatment: I hereby authorize the staff of VCA to render any treatment that is deemed necessary to my pet(s) health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before, if time permits, proceeding with treatment. I understand that I will be financially responsible for all emergency procedures including the Estimate of Charges provided to me in person or over the telephone. I understand that professional fees are to be paid at the time services are rendered and a deposit is required on all pets admitted to the hospital.

Signature of Owner, Agent, or Good Samaritan _____	Date _____	Signature of Spouse _____	Date _____
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Please Circle Your Method of Payment: Cash - Check - Visa - MasterCard - Discover - American Express - CareCredit

VCA Park Cities Animal Hospital

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AT VCA ANIMAL HOSPITALS, WE CARE